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Communicating With Hearing-Impaired Patients

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One aspect of establishing effective communication between physicians and patients has not received adequate attention: the special needs and challenges presented by patients with impaired hearing. In this article the term "hearing impaired" is generic and is applied to both those persons who are commonly labeled "deaf" and those labeled "hard of hearing" as a result of a bilateral hearing loss. The general skills, both verbal and nonverbal, that a physician must have in order to communicate successfully with a hearing-impaired patient are in essence the same as those required for a hearing patient. Where the divergence occurs is not in the basic skills (empathy, probing and the like) but rather in the means of applying them. Communicating with a hearing-impaired patient makes the use of some combination of the following necessary: speech, hearing, speechreading (lipreading), writing, visual aids, visual language systems and the assistance of an interpreter.

PERSONS WHOSE HEARING has become impaired after the age of approximately 12 or 13 will probably be able to speak very intelligibly. The structure of their verbal production often will be no different than that of a person whose hearing is good. It is likely, however, that there will be some aberrance in voicing, and in the articulation of some vowels and consonants. The degree of this aberration will depend on the degree of loss, the person's training and other individual factors.

In those who have had a hearing loss before the age of approximately 12 or 13, there will be distortion of speech pattern, intonation and syntactic structure—to the point that most persons with a severe or profound loss that occurred before the age of 5 or 6 will have speech that is either totally incomprehensible or understandable only by those with a good deal of experience interpreting "deaf speech." With such patients a physician must rely on visual means of communication: writing, speechreading, visual media (charts, diagrams and the like), finger spelling and signing (visible, conceptual symbols, produced with the hands, face and body). For many in this group of patients a trained interpreter will be necessary for any communication between physician and patient to occur.

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Hearing

In general, it is better to assume that spoken communication alone will be insufficient, leaving it to the hearing-impaired patient to correct you if you are wrong. This information itself is not always easily obtained, as many hearing-impaired people, out of pride or habit, will smile and nod

as you question them and present information, when in fact they do not follow you at all or at least not completely. The smile and nod syndrome is noticeable in any situation where one language group meets another at different levels of common linguistic understanding, but with a hearing-impaired person working with a doctor, the clear communication of ideas on both sides must be constantly probed and refined for obvious reasons.

Many hearing-impaired people use hearing aids with varying degrees of benefit. For some, amplification allows them to function with little loss of auditory input. Others regain access to only part of the language-relevant auditory input and, for still another group, a hearing aid provides only cues to gross environmental noise. In this latter group, little or no linguistically useful information is received.

Speechreading

Many hearing-impaired persons will be good speechreaders. One must realize, however, that for standard English only about 30 percent of the speech sounds, or phonemes, are visible on the lips under ideal conditions.[1] Assuming no linguistically useful residual hearing, the rest of the information must be filled in by speechreaders based on their knowledge of standard English structure, on their knowledge of the topic being discussed and on their general level of verbal sophistication. As a result of these differences and an elusive talent variable, persons with the same degree of loss will vary tremendously in their ability to receive communication through speechreading alone.

Through a combination of speechreading and amplification, some persons will be able to combine the auditory and visual cues successfully enough to carry on a conversation with only occasional problems. However, as noted before, for many persons no linguistic gain can be noted and a hearing aid serves only to maintain an awareness of environmental noise.

The use of medical terminology or other specialized language is a special problem for hearing-impaired patients. All speechreaders must rely heavily on their previous experience with the vocabulary and topic at hand. Any massive influx of new vocabulary will greatly impede their ability to follow a speaker. For those who operate at the lower levels of speechreading skill, the problem becomes greatly magnified. Obviously, a physician must be ready to convey ideas at varying levels of vocabulary difficulty.

Writing

Probably the first communication alternative that a physician might think of using when normal conversation is blocked is the use of writing. Writing can be used successfully with some hearing-impaired patients, especially when used in combination with understandable or partly understandable patient speech and good speechreading by the patient of the doctor's speech.

Two factors must be considered before you decide to rely on writing as a supplementary mode or as the sole mode of communication. The first of these is the restrictive nature of writing. It is slow, ponderous and frustrating to use as a conversational mode. Try carrying on a general conversation in writing with a hearing friend for half an hour or 45 minutes—then do the same thing on a technical topic about which only one of you is knowledgeable.

A second consideration is the patient's knowledge and understanding of standard English. In the deaf community, the terms "high verbal" and "low verbal" are frequently used to describe a hearing-impaired person's knowledge of and ability to communicate in standard English. A high verbal person is one who has very good to perfect mastery of standard English structure, a large vocabulary and generally high levels of traditional verbal abilities. These persons may or may not have speech upon which you can rely, but they can produce and read written standard English very well. The low verbal members of the community will have varying degrees of mastery of standard English. The sentences they write will be simple and are likely to include grammatical structure which is unlike standard English. These persons have as their primary linguistic mode, Ameslan (American Sign Language), which is grammatically distinct from standard English. They will produce written information which you may or may not be able to use as an information source.

Further, they will have great difficulty following your ideas if you use complex sentences or vocabulary. For the latter group, then, it is very likely that you will need an interpreter. For the former, it will depend partially on your patient's preference and partially on your judgment as to the success of your communication.

Visual Aids

The worn adage "a picture is worth a thousand words" is never truer than in work with hearing-impaired people. Any chart, diagram or picture that can be used to illustrate medical terminology or processes will be of great benefit to physician, patient and interpreter. Needless to say, the visual aids developed for such use would probably be of great value to many hearing patients.

Visual Language

Visual language takes a variety of forms in the hearing-impaired community. The decision as to whether it is necessary to include it in your relationship depends upon one factor. If a patient depends upon some form of visual language outside of your office, then he or she will need it inside your office. The form chosen will vary, but it probably will include some combination of the following:

Finger Spelling

In the American system of finger spelling, the preferred hand is used to spell out each word to be communicated. Each letter of the alphabet has a different hand configuration, and with experts, communication can be fairly rapid, though considerably slower than the spoken communication to which those with good hearing are accustomed. Though some persons have been trained and will continue to use finger spelling exclusively, most will use finger spelling only for those words, concepts and technical jargon for which no sign is available. With an expert using finger spelling at full speed, it is doubtful that an untrained observer could even begin to see the forms of letters at first. Reception involves specific perceptual and cognitive learning, as does any other form of linguistic communication. However, any physician who can finger spell and read finger spelling—even badly—tremendously facilitates his relationship with deaf patients. First, as with any linguistic group, the very fact that someone is willing to try to communicate in their language means a great deal to the hearing-impaired person. Patients will feel that such a physician is more likely to accept them, that he or she cares about them and in turn, they will be more likely to accept and trust the physician sooner. Hearing-impaired persons have suffered and continue to suffer a great deal of prejudice socially, vocationally and economically—not unlike that suffered by racial and ethnic minorities. As a result, for those whose identity is closely tied to the deaf community, there is a good deal of underlying mistrust and hostility toward the hearing world. This is often an important and sometimes difficult obstacle for a physician to overcome.

In an emergency situation, moreover, it is quite possible that the ability of a doctor to read and produce finger spelling—even slowly—could be a comforting, it not a lifesaving factor.

Signs

For vocabulary and concepts in general situations, a system of conceptual signs has been developed. The sign is a configuration of the body which stands for a concept or word, alleviating the need to use finger spelling for everything and making rapid conversation possible. The system of signs is growing rapidly to include more vocabulary. Fluent users frequently generate new signs which are specific to their needs in their own jobs and lives.

Whereas in standard English nuances of meaning are often communicated with the use of totally different words, in using these conceptional signs the nuance is often expressed by the use of the same basic sign with the addition of a change in other parts of the body, such as facial expression, or with variation in the way the sign is produced (made very large, very small, very slowly, rapidly or vehemently, and the like). The boundaries between signing, mime and drama disappear for a fluent user of sign. As a communication medium, signing is rich, exciting and dramatic, serving hearing-impaired people as well as the spoken language serves those who hear.

Given the two modes discussed, finger spelling and signing, two general systems of communication are then used.

Ameslan

Ameslan, or American Sign Language, is the "native language" of most persons who identify themselves with the hearing-impaired community. Some learn it when they reject the hearing world or accept their deafness as adolescents or adults; others acquire it from parents, peers, or teachers in childhood. It is grammatically distinct from standard English. High verbal users of Ameslan will use signing, mime and finger spelling, where necessary, to carry on their daily lives. Low verbal users tend to rely more on signing and mime and less on finger spelling.

Manual or Signed English

In schools for deaf persons where standard English is taught and used, a second general form of sign language has developed. Signs drawn from Ameslan and finger spelling are integrated with the grammatical structure of standard English. Standard English word order, syntactic markers (*s, 's, n't,* for example), articles (*a, an, the*) and the like are added. In so doing, a bridge between visual language and standard English is provided which aids in the development of bilingual persons—people who can potentially operate well in both a standard English dominated society and in the hearing-impaired community. These "anglicized" forms of sign language are considerably slower and more tedious to use, if taken to the extreme, than is Ameslan. As a result, a high verbal hearing-impaired person who lives in both worlds will generally adjust his or her communication system to the audience. Among friends and family the communication tends toward heavier use of Ameslan. Among outsiders of various types, the communication is more carefully structured along standard English lines. While this bilingualism is the ideal, for many it is unattainable and it is the low verbal, exclusive Ameslan user with whom the physician will face the greatest challenge, even with the use of a highly skilled interpreter.

The Interpreter—Role and Function

An interpreter becomes a necessity as an interface between the hearing and the hearing-impaired in two basic situations:

- When one-to-one communication is impossible because of some combination of the factors discussed earlier,
- When the absolute importance of the communication (such as discussing a major surgical operation) or the imposition of time strictures leaves no room for slow or occasionally inaccurate communication.

In such cases, even a high verbal hearing-impaired person will often prefer the use of an intermediary. The interpreter's role then is to become the interface between the two primary participants, to rapidly and accurately transmit information and ideas from the hearing-impaired to the hearing and back again. Depending on the nature of the conversation and upon the degree of the match of the two persons' verbal abilities, the interpreter must choose between two additional functions—that of translating and that of interpreting. Translating involves the verbatim tranference of each participant's production, word for word. Both content and form, then, are held constant. This one-for-one transference is most easily attained between two persons who could be labeled high verbal.

Interpretation becomes necessary when there is likely to be a mismatch in the verbal abilities, vocabularies, and so forth, between the doctor and patient. In such a case if an interpreter directly translates a doctor's phrasing and words, the patient would be no better off. He or she could not understand the meaning of what was being said even though it was being transformed into visual language. Interpretation then involves keeping the ideas and concepts being communicated equivalent, while varying the absolute structure and vocabulary, so that both parties can understand what is being said. Consequently, an interpreter's task is not an easy one, and should not be undertaken in crucial situations except by highly skilled and trained interpreters. The use of friends or family members as interpreters should be avoided, especially when the possibility of discussion of sensitive information and the importance of confidentiality are considered.

The National Registry of Interpreters for the Deaf (NRID)* is an organization to which you or your patient may turn for selection of an appropriate interpreter. It is an organization that has developed rigid guidelines and certification procedures for those who wish to become interpreters and it can provide you with the names of certified interpreters in your area.

General Suggestions

In the initial contacts with a deaf patient, one should emphasize both the confidential nature of your conversations and your willingness to be stopped if you have said something that is unclear or if you are doing something that interferes with speech reading. During your interviews, you will need to probe carefully the patient's understanding of what you have said and be prepared to provide explanations of medical jargon in lay terms, should the terminology be new to the patient. In addition, sudden or unannounced shifts in topic can be very confusing and will often cause a breakdown in communication. Be sure

*Further information can be obtained by writing the National Registry of Interpreters for the Deaf, Post Office Box 1339, Washington, D.C., 20013.

to tell the patient that you are going to change topics and what you will be talking about.

Maintaining constant eye contact with patients is crucial, as they will tend to follow your glance around the room, expecting that someone has entered the room or that something is happening in another part of the room; on the other hand, they may assume that you are uncomfortable with them, bored or otherwise disinterested. They will watch your nonverbal behavior carefully for signs of shock, dismay or frustration. If you experience these, or other strong feelings, it is best to share these with deaf patients so as to expand the relationship rather than destroy it. It is also possible that anxiety may cause them to misinterpret your nonverbal behavior and become unnecessarily hurt, insulted or confused. It is important, therefore, that you watch their nonverbal behavior for cues of confusion or distress, and when you see such cues, investigate the source with them immediately.

Tips That Will Aid Speechreading

Keep a distance of between 3 and 8 feet between you and the patient and make sure that the lighting is good. Excessive brightness or heavy shadows on your face will interfere with speechreading, as will a strong light source coming from behind you (such as a window). In case of the latter, close the drapes or move your chair in front of a neutral surface.

Avoid odd lipstick configurations or heavy beards and moustaches which distort or hide your mouth. Always look directly at patients so they can see you full face; avoid glancing or wandering around the room, digging in files or blocking the patient's view of your face and mouth with your hands or other objects. It is best to speak at a normal conversational rate and in a normal conversational tone—unusual variance in either will so distort your speech patterns that speechreading will become difficult, if not impossible. Finally, be aware that loud speech can be painful to the wearer of a hearing aid and will not get additional sound through to a profoundly deaf person.

Tips On The Use Of Visual Materials

Visual aids can provide an extremely valuable source of information when used effectively. To this end, such aids should be propped up so that they are vertical and as close to you as possible without blocking your face. In this way a patient can see both you and the aid simultaneously, thereby avoiding having to constantly shift visual focus. Become skilled at working with a visual aid from behind so that you can point things out without changing the aid's position or your posture constantly.

Since the patient can look at only one thing at a time, do not talk about a visual aid and point to its intricacies simultaneously. Shift back and forth as the patient shows or communicates readiness to do so. Finally, it can be very helpful to have a bibliography of materials, to which you can refer patients if they wish to read more about something you have discussed.

Tips On The Use Of An Interpreter

It is preferable when choosing an interpreter to select one who is certified by the National Registry of Interpreters for the Deaf. Once the three of you are together (you, the patient and the interpreter) be sure to seat the interpreter as close as possible to you so that the patient avoids the "ping-pong" effect (excessive movement of the eyes between you and the interpreter). Emphasize to the interpreter your desire to be told if miscommunication is occurring somewhere or if time is needed to catch up or reexplain something, or for a brief break. It will greatly help an interpreter if you monitor him or her with your side vision. This allows you to develop the ability to tell how well the interpreter is keeping up with you and thereby to pause when he or she falls behind. In regard to your role, always talk directly to the patient and avoid talking about a patient in the third person. For example, avoid phraseology such as, "Tell her _____," or "Ask him _____." Finally, do not assume that you can relax your efforts to communicate if you have an interpreter. A trained interpreter will automatically avoid many of the pitfalls described earlier—an untrained or poorly trained one may not. Regardless, you must take an active role and keep track of what is going on.

It is hoped that the foregoing material will heighten your awareness and provide you with some strategies to increase your effectiveness in working with hearing-impaired patients. It will take time and practice for you to comfortably put these suggestions into operation—but it should be time well spent as reflected in both personal satisfaction and improved patient service.

REFERENCE

1. Jeffers J, Barley M: Speechreading-lipreading. Springfield, Ill, Charles C Thomas Publishers, 1971